BAPTIST PRIMARY CARE

New Patient Form

Today's Date: _____

Patients Name: _____ Age: _____ Date of Birth: _____

PAST HISTORY

Date of Last Menstrual Period:	Allergies: None	
Date of Last Pap Smear:	# of Children: # of Pregnancies:	
Date of Last Mammogram Exam:	Please List all Past Surgeries with Approximate Dates:	
Date of Last Prostate Exam:	Surgeries:	Date:
Last Colonoscopy:		
Date of Last Eye Exam:		

Please List All Personal Illness/ Injuries and approximate Dates:

Social History

Married: ☐ Single : ☐ Divorced: ☐ Widowed: ☐ Current Ocupation: _____

Smoker: Yes ☐ No ☐ How Much? _____ packs/day How Long? _____years Date Quit: _____

Alcohol: Yes ☐ No ☐ How Much? _____packs/day When? _____ Caffeine (coffee, tea) How much?_____/Day_____

Illicit Drug Use? _____None: ☐ Currently Using:_____ Prior Problem: Yes ☐ No ☐ Explain: _____

Exercise: Yes ☐ No ☐ How Often? _____

Family History

Check ONLY the boxes that are POSITIVE: Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐
Tuberculosis (TB) ☐ Kidney Disease ☐ Anemia ☐ Arthritis ☐
Mental Illness ☐ Cancer ☐

Please Explain any boxes that are checked: _____

Mother: Living: ☐ Deceased/Cause: _____ Age: _____ Father: Living: ☐ Deceased/Cause: _____ Age: _____
Sister Living: ☐ Deceased/Cause: _____ Age: _____ Brother: Living: ☐ Deceased/Cause: _____ Age: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER, HERBAL SUPPLEMENTS, AND BIRTH CONTROL

Medication	Dosage/ Frequency

BAPTIST HEALTH | Changing Health Care for Good.

Billing Information:
If we are participating providers with your insurance company and you provide us with your insurance information, we will file your insurance claim for you. Please make sure you have contacted your insurance company prior to your visit to confirm that we participate with your plan. After receiving the explanation of benefits statement from your insurance company you may receive a bill that reflects uncovered charges such as deductibles, co-payments or other expenses. Please have your insurance card with you at the time of your appointment. We accept cash/check, Visa, MasterCard, Discover, and American Express as forms of payment. Should you have any questions regarding your bill or insurance, please contact our billing department at (904) 202-1032.

Cancellation/ No-Show Policy:
Your appointment time is reserved especially for you. As a courtesy to our providers, staff, and other patients, we ask that you call at least 24 hrs in advance of your scheduled appointment time for cancellations. This allows the physicians to offer that time to another patient. If you forget or fail to arrive for your scheduled appointment, a $30.0 fee will be applied to your patient account. The fee is not billable to your insurance carrier. The same policy applies to appointments cancelled less than 24 hour notice. Patients who schedule and fail to keep three (3) office appointments run the risk of being discharged from the practice. We kindly ask that you call to notify our staff if you are running late, however, it will be at the physicians' discretion on whether you will be seen.

Prescription Refill Request:
Please allow 48 business hours for processing of all prescription refill requests. Please note that not all medications can be called into the pharmacy and may need to be picked up from the office. In addition, a follow up appointment may be required to refill a prescription.

Call Back Times:
Please allow up to 24 business hours for response to all non-urgent medical questions.

Diagnostic Testing Results:
Please be assured that our providers review all lab and imaging results when received. Our staff will notify you by phone of critical results. Otherwise, written correspondence is mailed to you (or sent to your patient portal) regarding non-urgent results and recommendations are given for follow up care. We encourage you to enroll in the MyBaptistConnect patient portal, as your results are also available electronically.

Medical Emergencies:
After hours, on weekends and holidays, there will be a physician available for telephone consultation regarding urgent health conditions. You may contact the on-call physician by calling our office telephone number and leaving a message with our answering service. If the condition is an emergency, proceed to the nearest emergency department at Baptist Medical Center or the nearest emergency department to your location.

Referrals:
You may be referred to a specialist for evaluation of specific health problems. You should be aware of the referral process required by your insurance company. Under many insurance plans, you will only be able to see participating specialty providers. If your insurance company requires a referral, please allow 7-10 business days for completion. Every effort is made to have your referral completed in a timely manner.

By signing below, I acknowledge that I have read, understood, and agreed to the policies described above.

Print Name _____ Signature _____ Date _____

Name : _____

DOB: _____ SS# _____

New federal government guidelines require the following information be recorded in patient's medical records:

RACE: __Black, African American __Asian __White
__American Indian, Alaska Native
__Native Hawaiian, Other Pacific Islander
__Declined __Unknown

Ethnicity: __Hispanic or Latino __ Not-Hispanic or Latino
__Unknown __Declined

Primary Language: _____ __Declined

Tobacco: __Never a Smoker __Former Smoker __ Current Every Day Smoker
__Smokeless Tobacco

Allergies: __No Known Drug Allergies
__Allergic To: _____ Reaction _____
__Allergic To: _____ Reaction _____
__Allergic To: _____ Reaction _____

Would you like an invitation to My Baptist Connect Patient Portal? ___Yes ___No

If yes please provide email address _____

Please Write Legibly

Patient Signature _____ Date: _____